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SUPRA-PUBIC PROSTATECTOMY

IN A PATIENT AGED SIXTY-NINE YEARS, THE SUBJECT OF PROFUSE HÆMATURIA FROM AN UNUSUAL SOURCE: RECOVERY.[1]

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L. G. M., æt. sixty-nine years, in vigorous health until ten years ago, when symptoms of urinary obstruction from an hypertrophied prostate began.

Not long after this he had an attack of retention of urine, which was relieved by a metal catheter, and the instrument was used to draw the water for a few days (he then had a prostatic abscess?, which evacuated, apparently spontaneously, into the urethra).

Five years ago occurred a second attack of retention, followed by inability to pass the urine naturally, and the necessary regular use of the catheter, which condition has persisted ever since. Three years ago first noticed blood in the urine: the hæmorrhage was profuse, filling the bladder with clots which could not be evacuated through the catheter, and causing great distention of the bladder. This first attack of the bleeding apparently had no connection with the use of the catheter.

The bleeding was repeated only two or three times in each of the first two years following its first appearance.

[1] Read before the Society for Medical Improvement, Feb. 11, 1889.

But during the last year it has become more frequent, latterly once in about two months. The quantity of blood is generally great at the onset of the attack, then gradually diminishes during the succeeding days, leaving the urine quite clear at the end of about a week. The hæmorrhages are independent of exertion, and there is no pain except from the retention due to the over-distention from clots. During the past year the patient *thinks* he has noticed fleshy bits in the urine. There has been no pain. The history is, as you see, absolutely typical of bladder tumor, lacking only the positive confirmation of seeing the growth with the cystoscope, or finding the characteristic fragments microscopically in the urine. Such confirmation the patient *stated* he had received in New York, from a physician of high authority, who, the patient says, told him that a villous growth was plainly visible through the cystoscope, and that the microscopic examination also furnished further proof of its presence.

This I have noted, in order to make prominent the fact that an exceptional condition may (if the patient correctly quoted the doctor's opinion) lead, as in this instance it proved to be, to a faulty diagnosis, even in the presence of such positive proof as was furnished.

When the patient came to me early in December he was very anæmic and still weak from his last hæmorrhage, about a month previous. During three days I examined the urine, failing, however, to find any positive evidence of a bladder tumor. Two things, however, were evident, namely, the hæmorrhages were of undoubted bladder origin, and they undoubtedly meant the patient's death at no remote period. Upon these grounds I advised operation.

The choice of routes into the bladder was through the perinæum or from above the pubes. As he had a greatly lengthened posterior urethra due to the prostatic hypertrophy, and also a large and distensible bladder easily raised above the symphysis pubis, the latter way was selected. The cystotomy was done in the usual manner, with Petersen's technique. The inner surface of a thin-walled bladder was found to be entirely smooth, and no villous or other growth was present, except the projecting lateral portions of a greatly enlarged prostate. These jutted boldly backward into the cavity of the bladder, each lateral portion being about the size of a very large Spanish chestnut. They were connected by a less prominent median ridge, which had been perforated about half-way from its base, at some time previous, by an instrument. Surrounding this hole was a surface of the size of the end of one's thumb, covered with flabby and exuberant granulations, and this area was the only intravesical source of the hæmorrhages to be found. The lateral portions of the prostatic hypertrophy were then divided into halves by a blunt pointed bistoury, and each portion removed by a wire ecraseur to its base; the median portion, together with its granulating surface, was taken away with scissors and curette.

The bladder and outer wounds were both left open, and a large double rubber drain, reaching to the bottom of the bladder, was placed in them. Hemorrhage during and after the operation was but slight, and ceased on the fourth day, recurring for one day moderately, when the sloughs separated from the wounds at the end of two weeks. There has been none since (three months). A single drainage-tube was substituted at the end of a week, and

all drainage was removed on the twelfth day. The wounds united on the sixteenth day, and the patient was up and about on the eighteenth day. A week later, having been very restless, and sleepless for four nights preceding, heart failure occurred, the first sound becoming scarcely audible; the pulse rose to 100–110. The urine rapidly diminished in quantity, and was deficient in its solid constituents. The patient was pallid, and greatly prostrated. Dr. Whittier saw him at this time in consultation. Digitalis, stimulants, and appropriate feeding restored the patient. On substituting tinct. strophanthus for the digitalis forty-eight hours later, he relapsed into his former dangerous condition, which was again overcome by digitalis, etc. From this time he steadily gained, and went home at the end of six weeks from the date of operation, and has continued to do well since then; voluntary power of urination was not, however, restored. He reports, a day or so since, rapid gain in strength, and in all respects.

This case presents, I think, points of unusual interest, the chief of which is that already noticed, namely, that in rare instances prostatic hypertrophies may so simulate symptomatically in every respect other bladder growths (papilloma, etc.) as to entirely mislead, and furnish much apparently positive evidence of their existence.

Another matter of importance in connection with such a case is the advice as to operation. If the diagnosis is of bladder tumor, operation looking to *its removal* should always be advised, provided it is believed to be benign, and unless the patient is too far exhausted to undergo the operation. This in view of the successful results attained in many instances, and the necessarily fatal termination of the disease, if left to take its course.

If the growth is, on the other hand, believed to be cancerous, then the decision as to surgical interference turns on the question of pain; if this be severe a palliative operation by drainage should be advised; if painless, the disease had better be left to itself, in view of the inevitable result in any case.

Advice as to operative interference in cases of prostatic hypertrophy should, I think, be based upon the indications that I have recently pointed out in a work upon this subject ("On the Operative Treatment of the Hypertrophied Prostate"), viz., "Necessary, frequent (once an hour), painful catheterization, or urination without the catheter, especially when accompanied by a foul or hæmorrhagic cystitis. Attacks of retention; and failure to relieve such condition by palliative treatment." When such symptoms are present in any patient, and due to obstructive enlargement of the prostate, operation should, I think, almost always be advised, and undertaken before the patient is so reduced by the effects of the malady as to make the operation almost necessarily fatal, and consequently impracticable. I need not delay here to discuss operative methods. It is unquestioned, of course, that under the best of circumstances extensive surgical procedures, in these cases, will always be dangerous, and that fact must of course always be included in advising them. But such risks are, I think, to be preferred, in view of the highly probable benefit attending a successful issue, to the inevitable and near end of the patient's life, and the constant torture he must experience in whatever interval may precede that termination, if the case be left to palliative measures that have already proved ineffectual. I know of no picture more pitiable than that of an old man, a slave to the

constant and painful use of the catheter and a tormenting desire to urinate. In the case I have reported the operation was not undertaken primarily for relief of the obstruction to urination (for the patient's bladder was quiet), but to avert if possible death from hæmorrhages. This object is in all probability accomplished.

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